BIMTEK

PELAYANAN PERAWATAN PALIATIF DAN PERAWATAN AKHIR KEHIDUPAN

dr. Ika Syamsul Huda MZ, SpPD, MPH
Ketua Tim Perawatan Paliatif
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https://khn.org/wp-content/uploads/sites/2/2017/02/end-of-life0217_770.jpg?w=770

CURICULUM VITAE

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Keluarga : Istri : **Emy Poerbandari**
Anak : 1. Missy Savira
: 2. Qori El-Hafizh

Pendidikan : - **Program Pendidikan Dokter Spesialis Penyakit Dalam**
Universitas Diponegoro, Tahun 1998
- **Magister Manajemen Rumahsakit**
Universitas Gadjah Mada, Tahun 2010

Pekerjaan : Staf KSM Penyakit Dalam RSUP dr. Kariadi
Ketua Tim Perawatan Paliatif RSUP dr. Kariadi
Anggota Perhimpunan Dokter Paliatif Indonesia (PERDOPIN)
Anggota Masyarakat Paliatif Indonesia (MPI)

BIMTEK PELAYANAN PERAWATAN PALIATIF DAN AKHIR KEHIDUPAN
RSUD TUGUREJO
KAMIS, 13 FEBRUARI 2020

Mapping levels of palliative care development in 198 countries: the situation in 2017

INDONESIA:
Isolated Palliative Care Provision

A country in this category is characterized by the development of palliative care activism that is still patchy in scope and not well-supported; sources of funding that are often heavily donor-dependent; limited availability of morphine; and a small number of palliative care services that are limited in relation to the size of the population.

Prof. David Clark, dkk 2019

MYTHS ABOUT PALLIATIVE CARE

MYTH 7: Palliative care is only provided in a hospital.

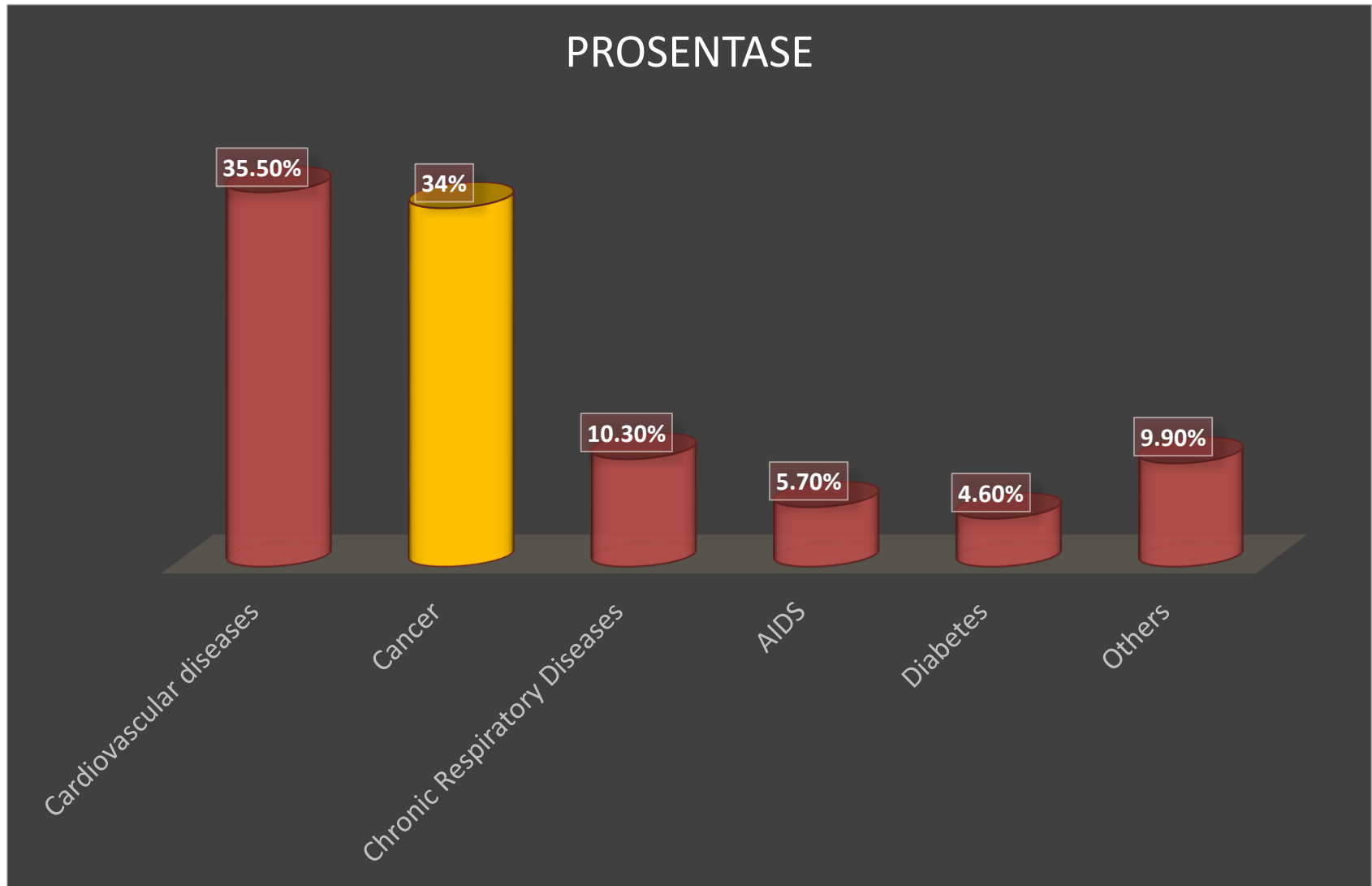
FACT: In many cases palliative care can be provided wherever the patient lives – home, long-term care facility, hospice or hospital. Sometimes the needs of the patient exceed what can be provided at home despite best efforts.

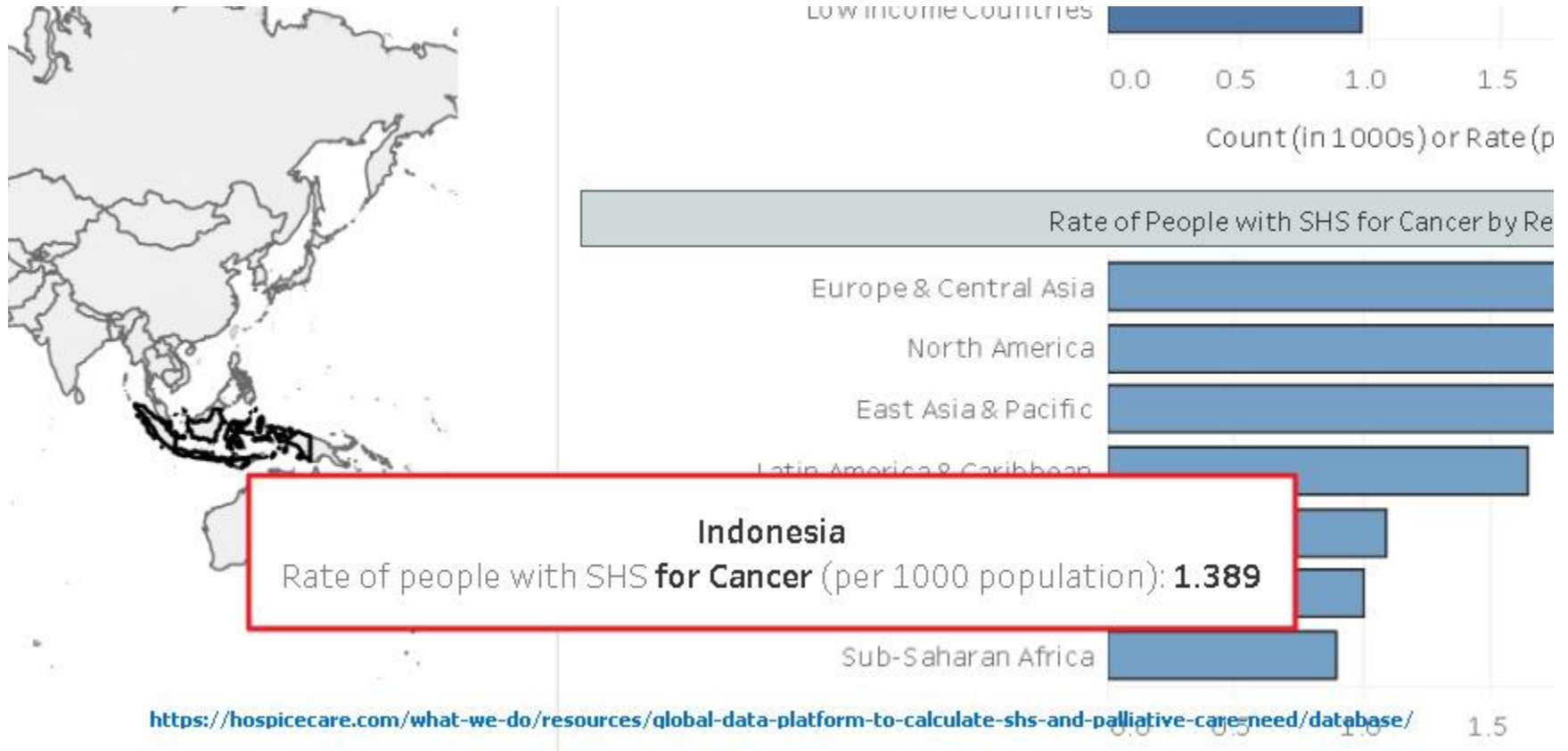
MYTH 9: Palliative care is only for people dying of cancer.

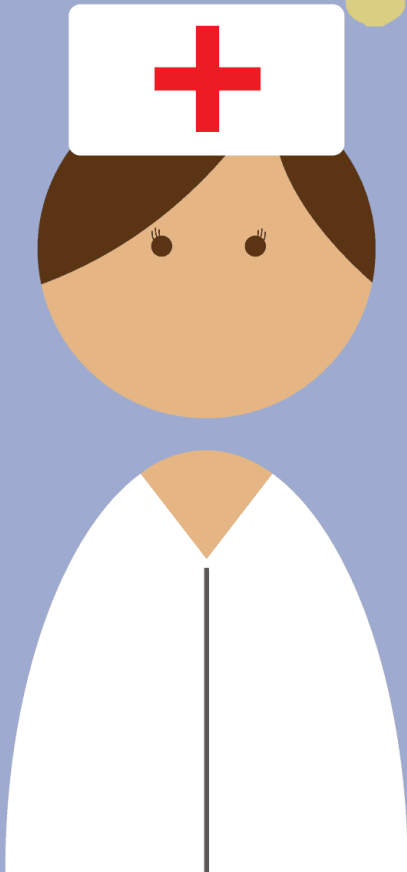
FACT: Palliative care can benefit patients and their families from the time of diagnosis of any life-limiting illness.

https://www.nygh.on.ca/data/2/rec_docs/3244_Palliative_Care_Myths_and_Facts_Infographic_May2018.pdf

PALLIATIVE CARE IS REQUIRED FOR A WIDE RANGE OF DISEASES

http://www.who.int/en/news-room/fact-sheets/detail/palliative-care

POPULASI PENDERITA KANKER DI INDONESIA (2015)

https://hospicecare.com/what-we-do/resources/global-data-platform-to-calculate-shs-and-palliative-care-need/database/

PELAYANAN KESEHATAN

Promotif
Preventif
Kuratif
Rehabilitatif
Suportif
Paliatif

HISTORY OF PALLIATIVE CARE

Dame Mary Cicely Saunders
(22 Juni 1918 - 14 Juli 2005)

TOTAL PAIN

MODERN HOSPICE (1960)

http://www.case-stories.org/total-pain-and-social-suffering/

dr. Balfour Mount
Born 14 April 1939
Urological surgeon
Father of Canada's palliative care movement

PALLIATIVE

Palliare (Bahasa Latin) = to cloak, cover

jubah, mantel

Butterflies are known as a symbol of transformation, hope, life, and spirit. Hospices across the country hold butterfly releases to help those who are grieving, remember and honor their loved ones. Another way hospice helps care and nurture their families and the communities they serve.

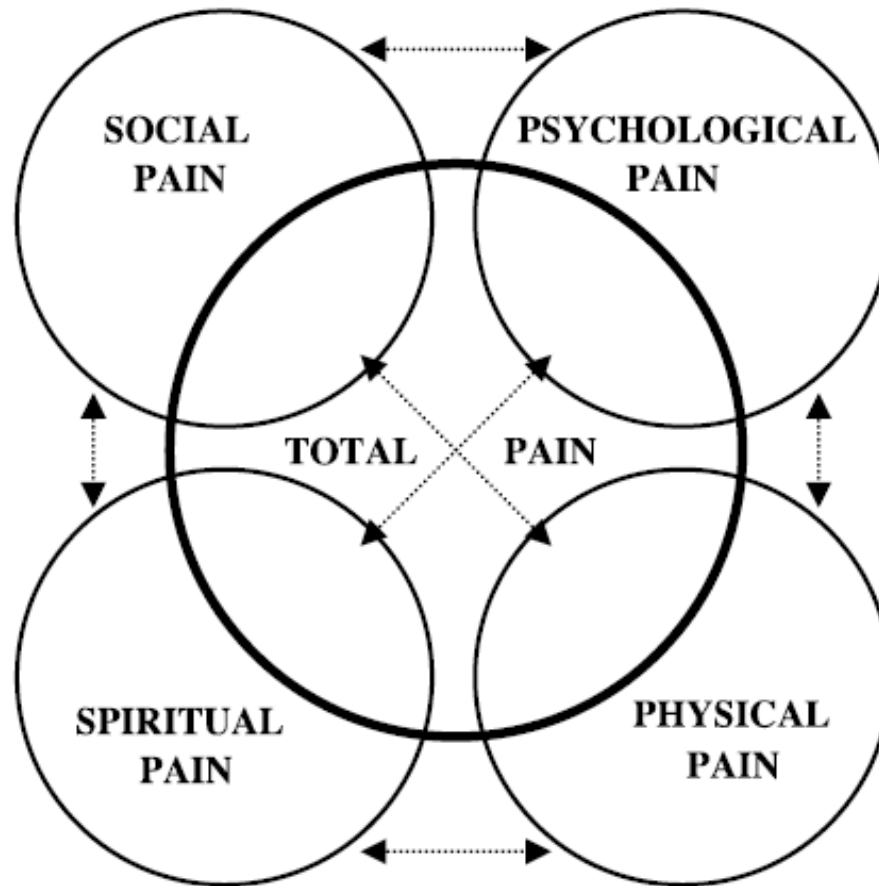
https://www.facebook.com/NHPCO/posts/butterflies-are-known-as-a-symbol-of-transformation-hope-life-and-spirit-hospice/10155750819413907/

TOTAL PAIN

Figure 1. The total pain experience: an interactive model.

WHO Definition of Palliative Care

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.

http://www.who.int/cancer/palliative/definition/en/

The **holistic approach** looks at problems in four groups:

- **Physical** – symptoms (complaints), eg pain, cough, tiredness, fever
- **Psychological** – worries, fears, sadness, anger
- **Social** – needs of the family, issues of food, work, housing and relationships
- **Spiritual** – questions of the meaning of life and death, the need to be at peace.

Quality of Life (QoL)

Kualitas hidup (QoL) didefinisikan sebagai persepsi individu tentang posisi mereka dalam kehidupan dalam konteks budaya dan sistem nilai di mana mereka hidup dan dalam kaitannya dengan tujuan, harapan, standar, dan kekhawatiran mereka. Ini adalah konsep luas yang dipengaruhi secara kompleks oleh kesehatan fisik seseorang, keadaan psikologis, tingkat kemandirian, hubungan sosial, dan hubungan mereka dengan ciri-ciri menonjol dari lingkungan mereka.

Physical

Functional Ability
Strength/Fatigue
Sleep & Rest
Nausea
Appetite
Constipation
Pain
Dyspnea

Psychological

Anxiety
Depression
Enjoyment/Leisure
Pain/Dyspnea Distress
Happiness
Fear
Cognition
Attention

Social

Financial Burden
Caregiver Burden
Roles and Relationships
Affection/Sexual Function
Appearance

Spiritual

Hope
Suffering
Meaning of Pain/Dyspnea
Religiosity
Transcendence

Adapted from Ferrell et al., 1991

Dasar Acuan

KEPUTUSAN MENTERI KESEHATAN REPUBLIK INDONESIA

NOMOR : 812/Menkes/SK/VII/2007

TENTANG

KEBIJAKAN PERAWATAN PALIATIF

MENTERI KESEHATAN REPUBLIK INDONESIA

Pada tanggal : 19 Juli 2007

Dr. dr. SITI FADILAH SUPARI Sp.JP (K)

http://dinkes.surabaya.go.id/portal/files/kepmenkes/skmenkes812707.pdf

LINTASAN SAKIT

High

"Cancer" Trajectory, Diagnosis to Death

Cancer

Organ System Failure Trajectory

(Mostly heart and lung failure)

Function

Low

Frailty / Dementia Trajectory

Death

Death

Death

Onset of incurable cancer → Time – Often a few years, but decline usually seems <2 months

Begin to use hospital often, self care becomes difficult → Time ~ 2-5 years, but death usually seems "sudden"

Onset could be deficits in ADL, speech, ambulation → Time ~ quite variable ~ up to 6-8 years

ILLNESS TRAJECTORY

Department of Health, Western Australia. Palliative Care Model of Care. Perth: WA Cancer & Palliative Care Network, Department of Health, Western Australian; 2008.

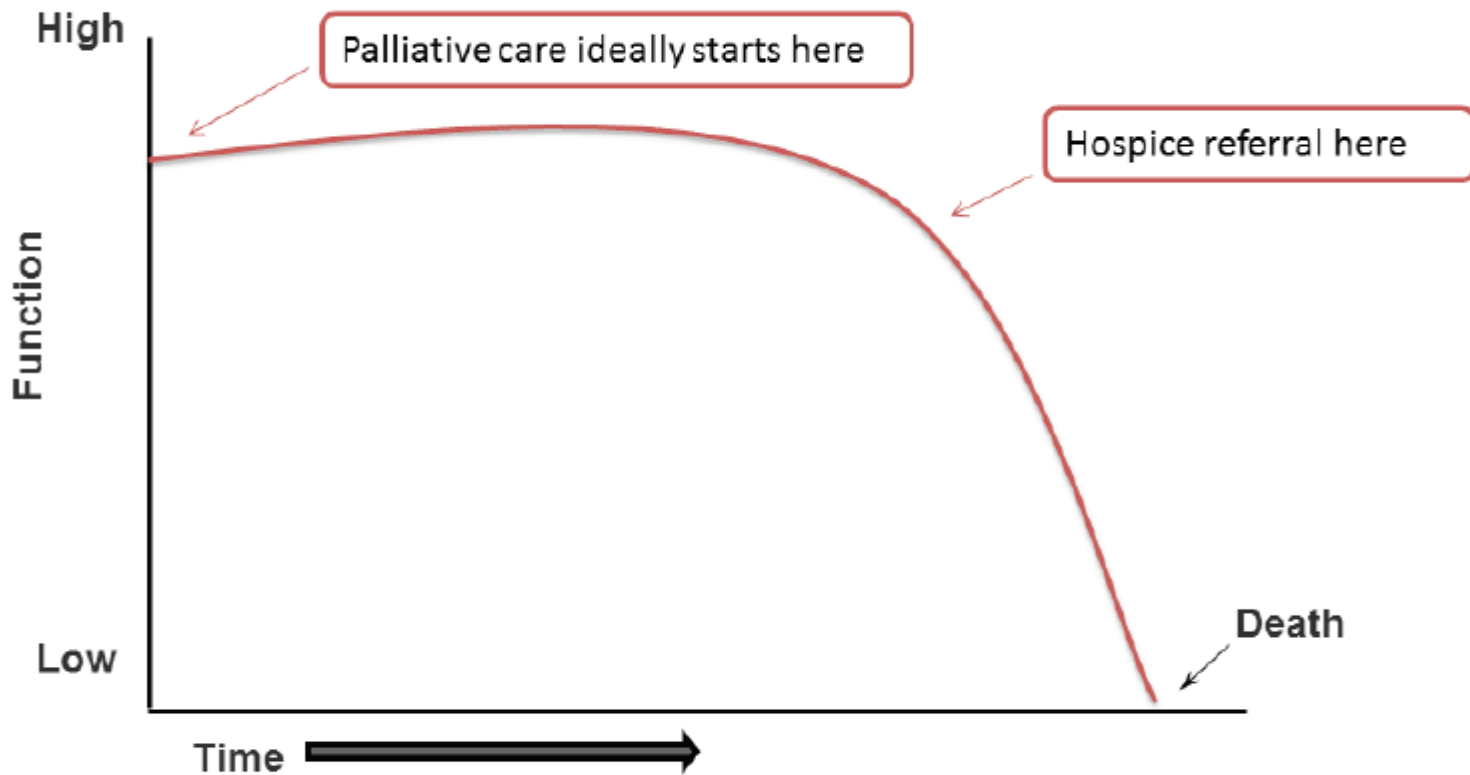



Figure 2: Terminal Disease Trajectory. Adapted with permission from Lynn, 2004.

MODEL BARU PERAWATAN PALIATIF

Curative Care
(= disease-specific, restorative)

Bereavement

Palliative Care
(= supportive, symptom-oriented)

Diagnosis

Dying

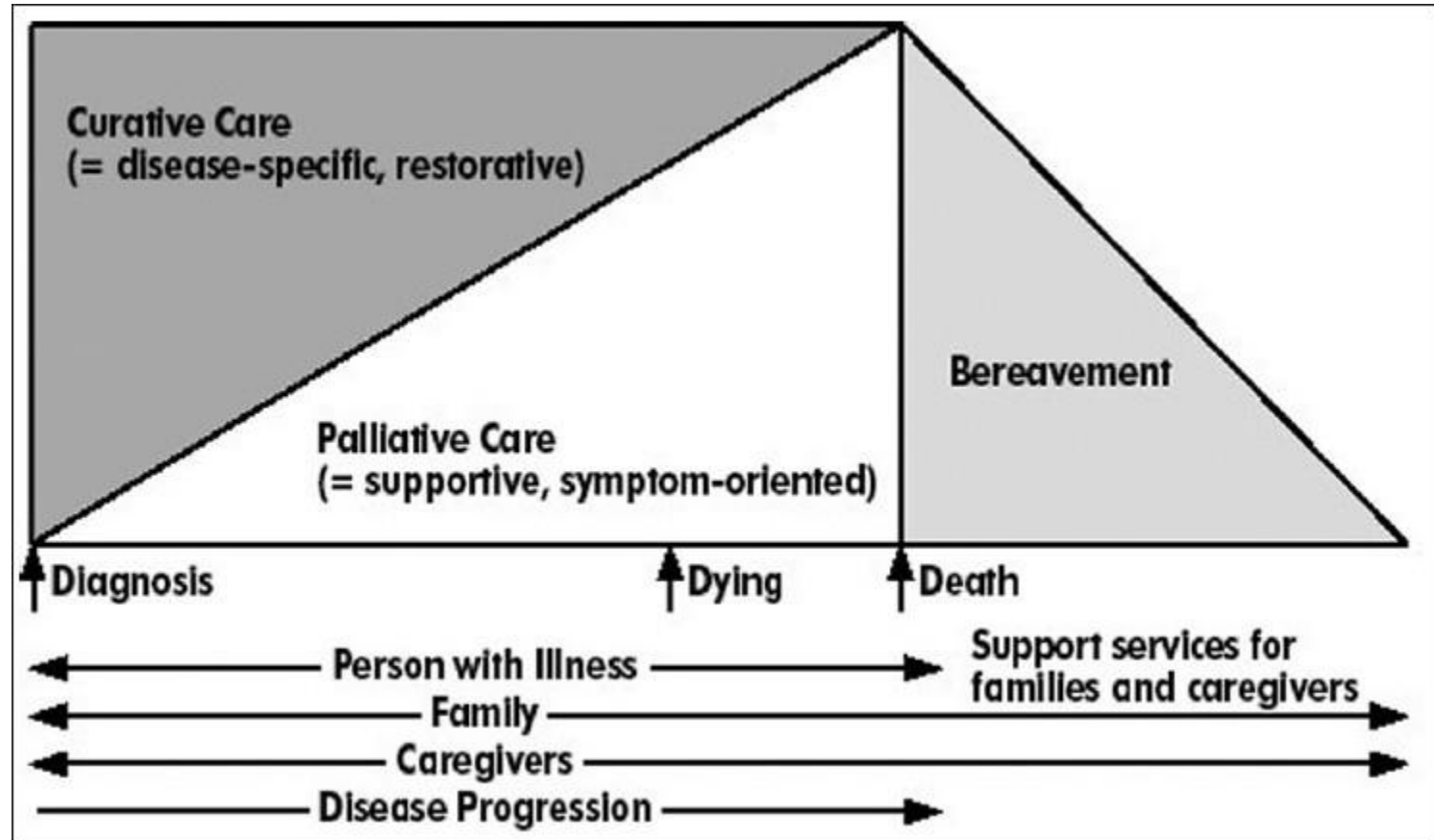
Death

Person with Illness

Support services for
families and caregivers

Family

Caregivers

Disease Progression

http://www.jpalliativecare.com/articles/2010/16/3/images/IndianJPalliatCare_2010_16_3_107_73639_f1.jpg

PATIENTS ARE

‘APPROACHING THE END OF LIFE’

WHEN THEY ARE LIKELY TO DIE WITHIN THE NEXT 12 MONTHS.

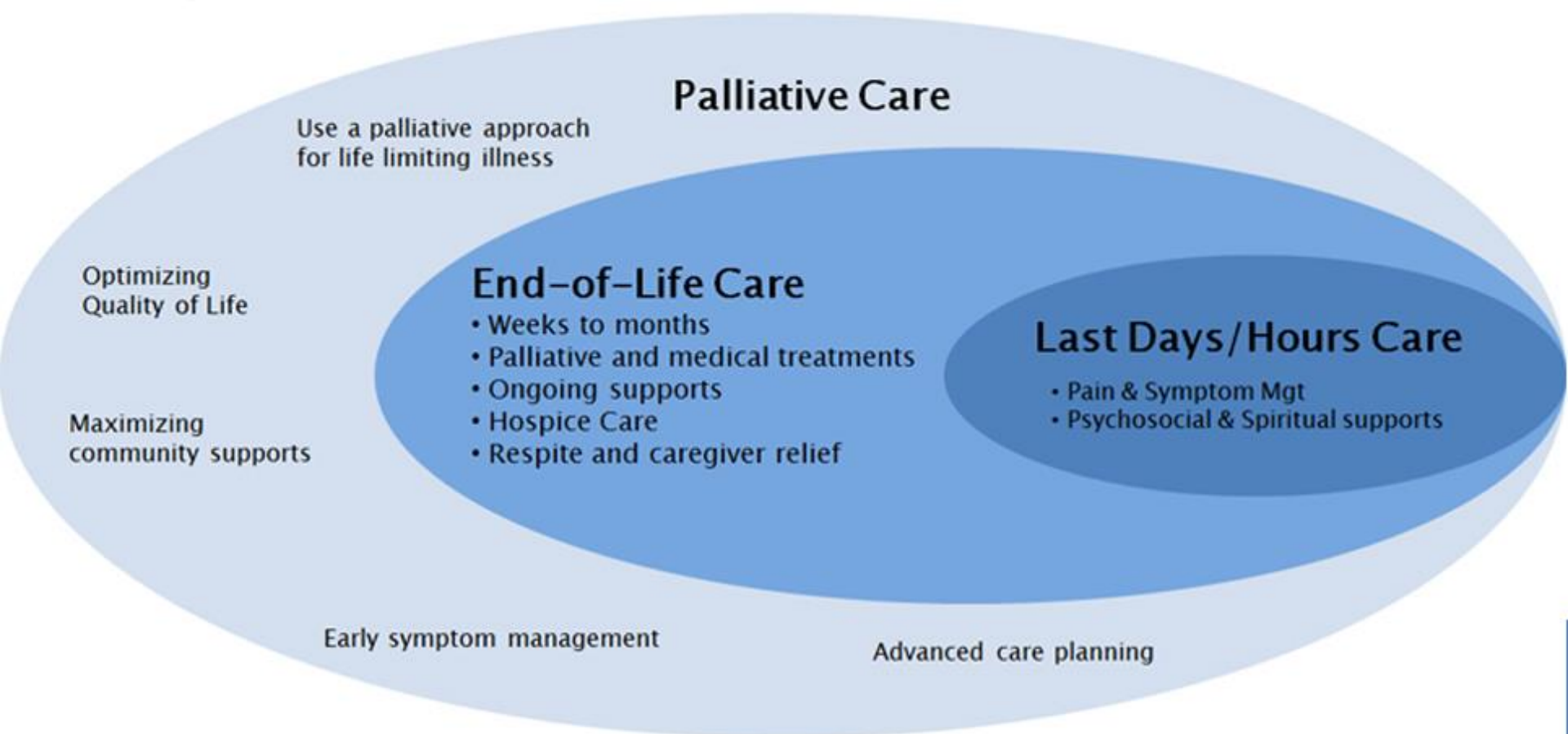
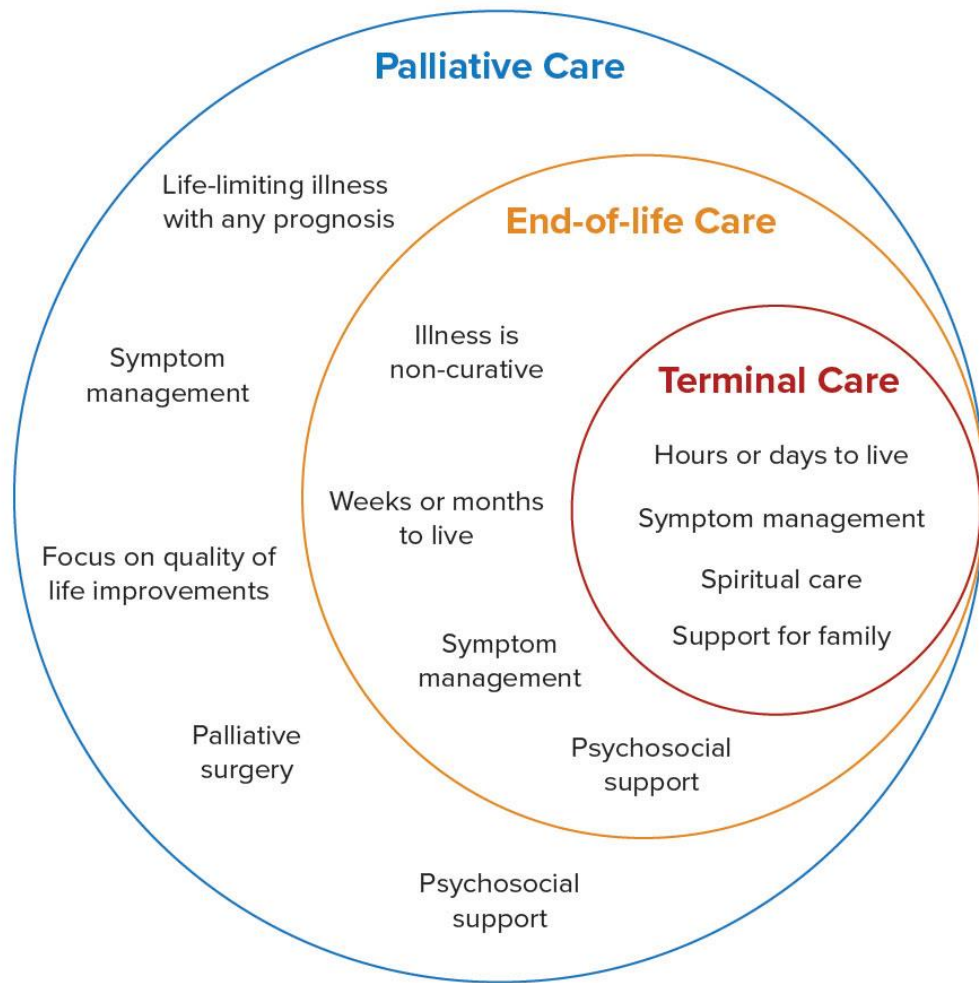
https://web.archive.org/web/20101130194228/https://www.gmc-uk.org/static/documents/content/End_of_life.pdf

THE END OF LIFE

THE END OF LIFE				THEY DYING PHASE
At risk of dying in 6 – 12 months, but may live for years	MONTHS 2 – 9 months	SHORT WEEKS 1 – 8 weeks	LAST DAYS 2 – 14 days	LAST HOURS 0 – 48 hours
DISEASE(S) RELENTLESS Progression is less reversible Treatment benefits are waning	CHANGE UNDERWAY Benefit of treatment less evident Harms of treatment less tolerable	RECOVERY LESS LIKELY The risk of death is rising	DYING BEGINS Deterioration is weekly/daily	ACTIVELY DYING The body is shutting down The person is letting go

Figure 1.5 Time frames in the dying process[1]

Reproduced from *Independent Review of the Liverpool Care pathway: More Care, Less Pathway*, Williams Lea, London, UK, © Crown Copyright 2013, licensed under the Open Government Licence v.2.0.

https://www.interiorhealth.ca/YourCare/PalliativeCare/PublishingImages/whatispalliative-lg.jpg

Terminal Care

End-of-life Care

Palliative Care

Diagnosis ⟷ Death

End-Stage IndicatorsEnd-Stage Indicators

Cancer Diagnoses

1. Disease with distant metastases at presentation OR
2. Progression from an earlier stage of disease to metastatic disease with either:
   - a continued decline in spite of therapy
   - patient declines further disease directed therapy

INTEGRASI PERAWATAN PALIATIF

PALLIATIVE CARE

TIM PALIATIF

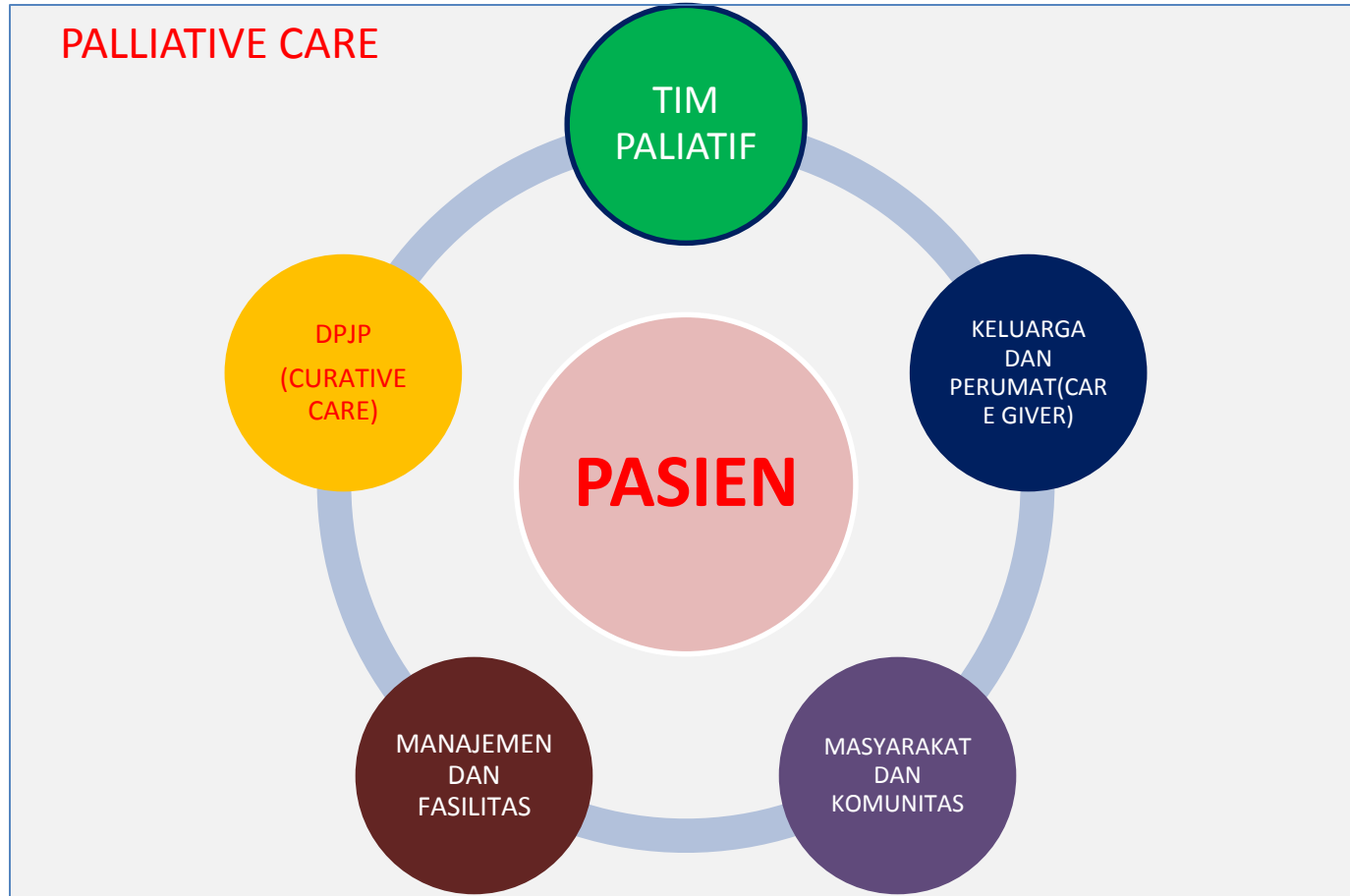
DPJP

(CURATIVE CARE)

KELUARGA DAN PERUMAT(CARE GIVER)

PASIEN

MANAJEMEN DAN FASILITAS

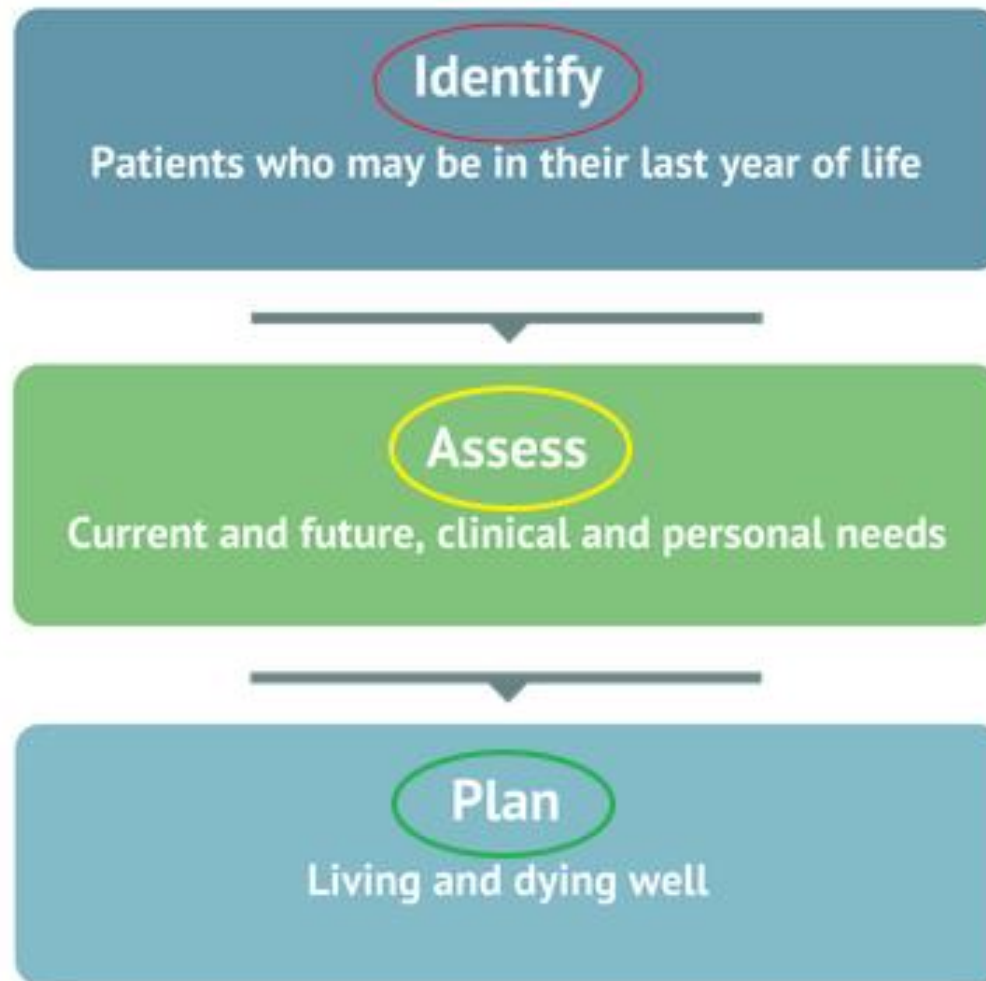
MASYARAKAT DAN KOMUNITAS

KERJASAMA TIM

TIM PERAWATAN PALIATIF RUMAH SAKIT

- Dokter
- Perawat
- Fisioterapis
- Farmasis
- Rohaniawan
- Pekerja sosial

Multidisipliner
Kolaborasi
Koordinatif

PROVIDING A PALLIATIVE APPROACH TO CARE

Step 1: Identify

Identify if the patient would benefit from palliative care earlier in their illness trajectory

Three **triggers** that suggest that patients could benefit from a palliative care approach:

1. **The Surprise Question:** 'Would you be surprised if the patient were to die in the next year?'
2. **General indicators of decline:** deterioration, advanced disease, decreased response to treatment, choice for no further disease modifying treatment.
3. **Specific clinical indicators** related to certain conditions.

Ask the Surprise Question

Would you be surprised if the patient were to die in next year, months, weeks, days?

listen
to your
intuition -
it's on
your side.

Bear in mind that even doctors with long experience tend to ***over-estimate prognosis.***
https://static.scientificamerican.com

Do they have
General Indicators
of Decline?

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Do they have Specific Clinical Indicators?

Cancer

- **Functional ability deteriorating** due to progressive cancer.
- **Too frail** for cancer treatment or treatment is for symptom control.

Tool

Supportive and Palliative Care Indicators Tool (SPICT™)

The SPICT™ is used to help identify people whose health is deteriorating.
Assess them for unmet supportive and palliative care needs. Plan care.

Look for any general indicators of poor or deteriorating health.

- Unplanned hospital admission(s).
- Performance status is poor or deteriorating, with limited reversibility. (eg. The person stays in bed or in a chair for more than half the day.)
- Depends on others for care due to increasing physical and/or mental health problems.
- The person's carer needs more help and support.
- Progressive weight loss; remains underweight; low muscle mass.
- Persistent symptoms despite optimal treatment of underlying condition(s).
- The person (or family) asks for palliative care; chooses to reduce, stop or not have treatment; or wishes to focus on quality of life.

Look for clinical indicators of one or multiple life-limiting conditions.

Cancer

- Functional ability deteriorating due to progressive cancer.
- Too frail for cancer treatment or treatment is for symptom control.

Dementia/ frailty

- Unable to dress, walk or eat without help.
- Eating and drinking less; difficulty with swallowing.
- Urinary and faecal incontinence.
- Not able to communicate by speaking; little social interaction.
- Frequent falls; fractured femur.
- Recurrent febrile episodes or infections; aspiration pneumonia.

Neurological disease

- Progressive deterioration in physical and/or cognitive function despite optimal therapy.
- Speech problems with increasing difficulty communicating and/or progressive difficulty with swallowing.
- Recurrent aspiration pneumonia; breathless or respiratory failure.
- Persistent paralysis after stroke with significant loss of function and ongoing disability.

Heart/ vascular disease

- Heart failure or extensive, untreatable coronary artery disease; with breathlessness or chest pain at rest or on minimal effort.
- Severe, inoperable peripheral vascular disease.

Respiratory disease

- Severe, chronic lung disease; with breathlessness at rest or on minimal effort between exacerbations.
- Persistent hypoxia needing long term oxygen therapy.
- Has needed ventilation for respiratory failure or ventilation is contraindicated.

Kidney disease

- Stage 4 or 5 chronic kidney disease (eGFR < 30ml/min) with deteriorating health.
- Kidney failure complicating other life limiting conditions or treatments.
- Stopping or not starting dialysis.

Liver disease

- Cirrhosis with one or more complications in the past year:
  - diuretic resistant ascites
  - hepatic encephalopathy
  - hepatorenal syndrome
  - bacterial peritonitis
  - recurrent variceal bleeds
- Liver transplant is not possible.

Other conditions

- Deteriorating and at risk of dying with other conditions or complications that are not reversible; any treatment available will have a poor outcome.

Review current care and care planning.

- Review current treatment and medication to ensure the person receives optimal care; minimise polypharmacy.
- Consider referral for specialist assessment if symptoms or problems are complex and difficult to manage.
- Agree a current and future care plan with the person and their family. Support family carers.
- Plan ahead early if loss of decision-making capacity is likely.
- Record, communicate and coordinate the care plan.

Please register on the SPICT website (www.spict.org.uk) for information and updates.

SPICT™, April 2019

https://www.spict.org.uk/

SPICT-App

https://www.spict.org.uk/spictapp/

Step 2: Assess

Assess the person's current and future needs and preferences across all domains of care.

Screening Tools

- **Edmonton Symptom Assessment System** (ESAS-r)
- **Palliative Performance Scale** (PPSv2)

https://www.ontariopalliativecarenetwork.ca/en/node/31896

Edmonton Symptom Assessment System:

(revised version) (ESAS-R)

Cancer Care Ontario

Action Cancer Ontario

Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
No ________ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible ________

Patient's Name ______________________________

Date ________________ Time ________________

Completed by (check one):
- ☐ Patient
- ☐ Family caregiver
- ☐ Health care professional caregiver
- ☐ Caregiver-assisted

BODY DIAGRAM ON REVERSE SIDE

ESAS-r
Revised: 2015

Palliative Performance Scale (PPSv2)

version 2

PPS Level	Ambulation	Activity & Evidence of Disease	Self-Care	Intake	Conscious Level
100%	Full	Normal activity & work No evidence of disease	Full	Normal	Full
90%	Full	Normal activity & work Some evidence of disease	Full	Normal	Full
80%	Full	Normal activity *with* Effort Some evidence of disease	Full	Normal or reduced	Full
70%	Reduced	Unable Normal Job/Work Significant disease	Full	Normal or reduced	Full
60%	Reduced	Unable hobby/house work Significant disease	Occasional assistance necessary	Normal or reduced	Full or Confusion
50%	Mainly Sit/Lie	Unable to do any work Extensive disease	Considerable assistance required	Normal or reduced	Full or Confusion
40%	Mainly in Bed	Unable to do most activity Extensive disease	Mainly assistance	Normal or reduced	Full or Drowsy +/- Confusion
30%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Normal or reduced	Full or Drowsy +/- Confusion
20%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Minimal to sips	Full or Drowsy +/- Confusion
10%	Totally Bed Bound	Unable to do any activity Extensive disease	Total Care	Mouth care only	Drowsy or Coma +/- Confusion
0%	Death	-	-	-	-

Stable
70 – 100 %

Transitional
40 – 60%

End-of-Life
0 -30 %

www.victoriahospice.org/sites/default/files/pps_english.pdf

CONTOH KASUS

Pasien sangat lemah dan tetap berada di kursi beberapa jam sehari. Sisa waktu, dia sedang di tempat tidur. Dia memiliki penyakit lanjut dan membutuhkan bantuan yang hampir lengkap dengan perawatan diri dan makanan. Ia mengalami penurunan asupan makanan, dengan beberapa camilan kecil yang kebanyakan tetap belum selesai. Dia memiliki asupan cairan yang cukup. Pasien mengantuk *(DROWSY)* tapi tidak bingung *(CONFUSED).*

BERAPA PPS PASIEN TERSEBUT?

https://eprognosis.ucsf.edu/pps.php?p=palliative

https://eprognosis.ucsf.edu/pps.php?p=palliative

Family Meeting

INFORMATION

BREAKING BAD NEWS

FAMILY SUPPORT

ADVANCED CARE PLANNING

- VALUES
- WISHES
- BELIEFS
- PREFERENCES
- GOALS

- VALUES
- WISHES
- BELIEFS
- PREFERENCES
- GOALS

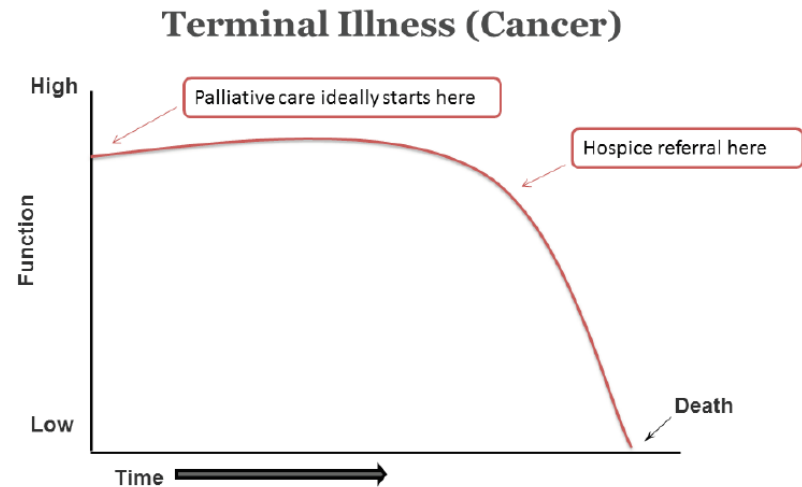



Figure 2: Terminal Disease Trajectory. Adapted with permission from Lynn, 2004.

NILAI – HARAPAN – KEYAKINAN - PREFERENSI - TUJUAN

BREAKING BAD NEWS

- Persiapkan dan Rencanakan
- Cari Tahu Apa yang Pasien dan Keluarga Tahu dan Ingin tahu
- Dukungan Emosi (Support Mental Pasien dan Keluarga)
- Membuat Rekomendasi
- Resolusi konflik

Memberikan informasi sesuai kebutuhan pasien dan keluarga.

- Berikan pasien kesempatan untuk membahas **harapan-harapannya**, atau disisi lain menghargai untuk tidak membahasnya jika pasien tidak menginginkannya.
- Berikan informasi secara **bertahap** sesuai yang diinginkan pasien.
- Gunakan bahasa yang **jelas dan mudah** dimengerti serta menghindari penggunaan istilah-istilah medis.
- Menjadi **pendengar** yang baik dan tanyakan kembali untuk memperjelas maksud pernyataannya.

- Jelaskan mengenai ketidakpastian dan keterbatasan dari **prognosis** dan **masa akhir kehidupan**.
- **Hindari memberikan batasan waktu kecuali kondisi pasien sudah terminal**

- Perhatikan juga hal-hal yang diperlukan oleh pelaku rawat. Pertimbangkan pertemuan terpisah antara pasien dengan pelaku rawat bila dibutuhkan.

- Berikan informasi dan pendekatan yang konsisten kepada setiap anggota keluarga pasien, pasien dan tim paliatif yang merawat.
- Minimalkan penggunaan kata-kata '**meninggal**' dan '**sekarat**' dalam diskusi.

TAHAPAN PSIKOLOGIS PASIEN DALAM MENGHADAPI KONDISI SAKIT

Kübler-Ross model

MORAL & COMPETENCE

Shock
Surprise or shock at the event

Denial
Disbelief; Looking for evidence that it is't true

Frustration
Recognition that things are different; sometimes angry

Depression
Low mood; Lacking in energy

Experiment
Initial engagement with new situation

Decision
Learning how to work in the new situation; feeling more positive

Integration
Changes integrated; a reniewed individual

TIME

The five stages are: DABDA

Denial - "It can't be happening."

Anger - "Why me?"

Bargaining - "Just let me live to see my grandchild born."

Depression - "God please don't take me away from my family."

Acceptance - a state in which there may be an intense longing for death.

Ethical Principles

- **Autonomy:** Making one's own decision
- **Beneficence:** Intending to do good
- **Nonmaleficence:** Intending to do no harm
- **Justice:** Providing equal access

1. *A person requires clear information to make autonomous decisions.*
2. *Beneficence intends best possible treatment for the individual.*
3. *Beneficence infers a balancing of possible benefits and possible risks or harms.*
4. *Beneficence requires clinicians to keep up to date with current knowledge.*
5. *Withholding or withdrawing treatment is ethically and legally acceptable if the treatment is futile.*
6. *A Living Will or Advance Directive provides guidance on a person's preferences for care.*

http://www.cmej.org.za/index.php/cmej/article/view/2181/1877

ETHICAL ISSUES IN PALLIATIVE CARE

- Withholding and Withdrawing Treatment
- How Much Care?
- Planning Care
- The Doctrine of Double Effect
- Cardiopulmonary Resuscitation (CPR)
- Palliative Sedation

Step 3: Plan and Manage

Plan and collaborate ongoing care to address needs identified during the assessment. This includes prompt management of symptoms and coordination with other care providers.

https://www.ontariopalliativecarenetwork.ca/en/node/31896

Collaborative Care Plans:

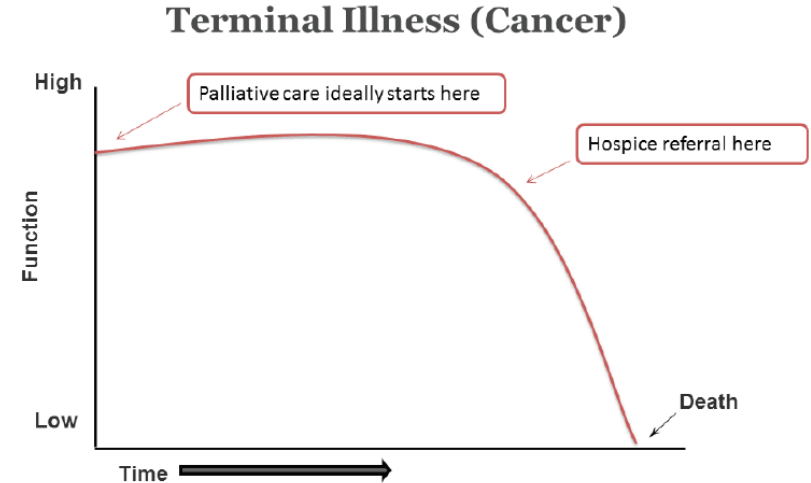
STABLE PHASE
(PPS 70—100%)

TRANSITIONAL PHASE
(PPS 40—60%)

END OF LIFE PHASE
(PPS 0—30%)

http://www.mhpcn.net/following-provides-local-relevance-each-collaborative-care-plan

11 SYMPTOMS

1. Pain
2. Anorexia
3. Nausea and vomiting
4. Constipation
5. Diarrhoea
6. Dyspnea
7. Fatigue
8. Delirium
9. Depression
10. Anxiety
11. Respiratory tract secretions

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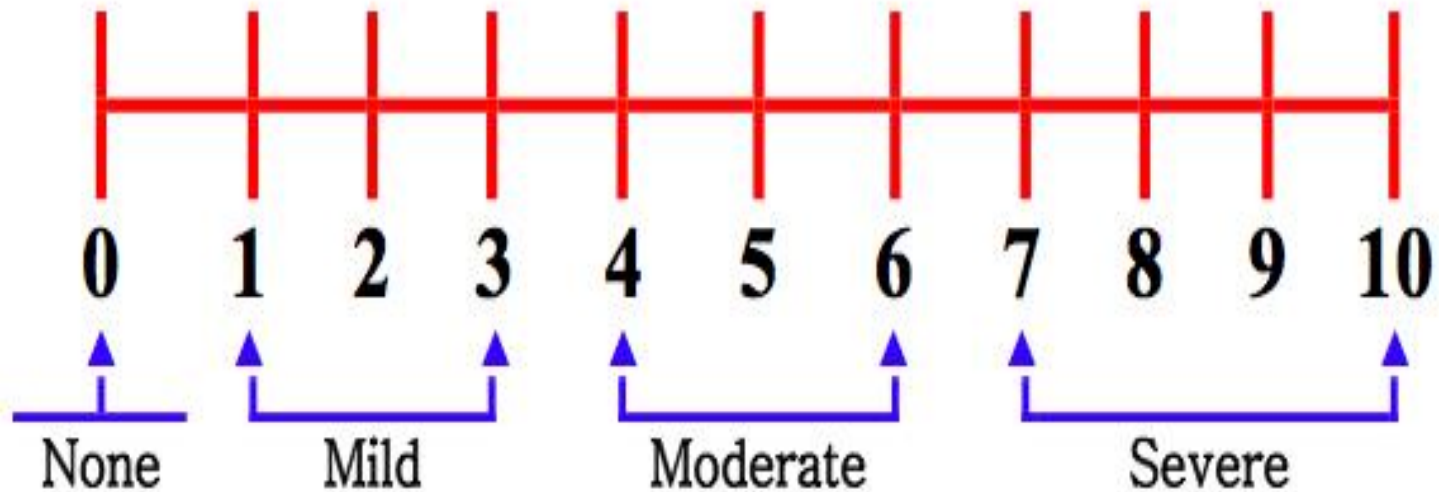
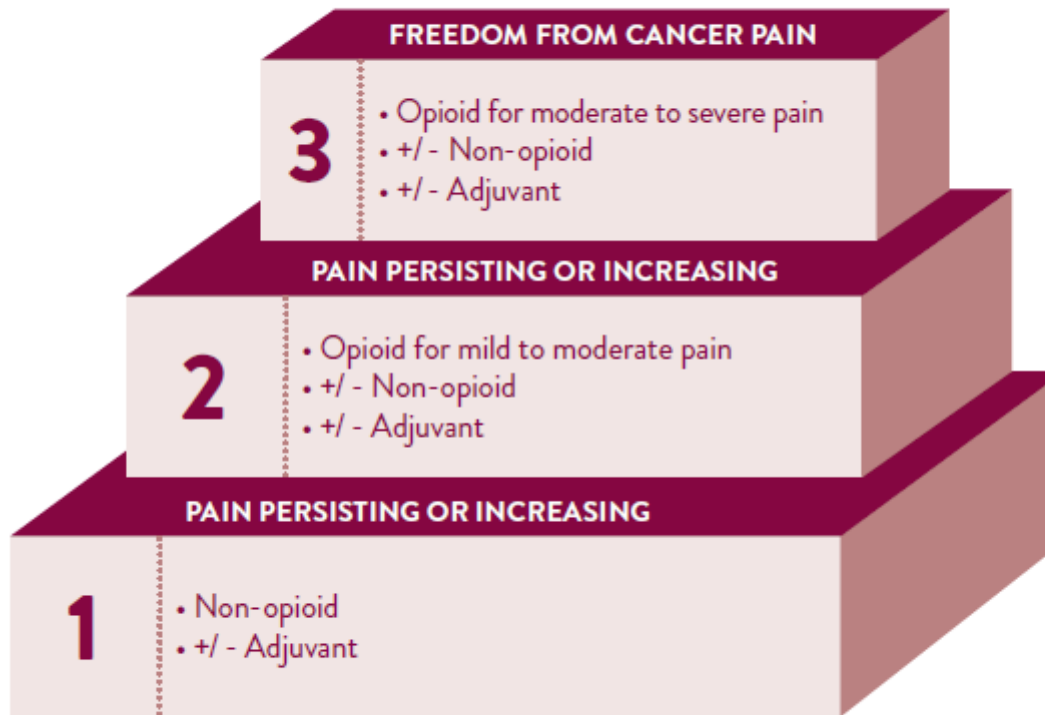
Edmonton Symptom Assessment System:
(revised version) (ESAS-R)

Please circle the number that best describes how you feel NOW:

PAIN	No Pain	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Pain
TIREDNESS	No Tiredness *(Tiredness = lack of energy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Tiredness
DROWSINESS	No Drowsiness *(Drowsiness = feeling sleepy)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Drowsiness
NAUSEA	No Nausea	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Nausea
LACK OF APPETITE	No Lack of Appetite	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Lack of Appetite
SHORTNESS OF BREATH	No Shortness of Breath	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Shortness of Breath
DEPRESSION	No Depression *(Depression = feeling sad)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Depression
ANXIETY	No Anxiety *(Anxiety = feeling nervous)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Anxiety
WELLBEING	Best Wellbeing *(Wellbeing = how you feel overall)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible Wellbeing
OTHER PROBLEM	No __________ Other Problem *(for example constipation)*	0	1	2	3	4	5	6	7	8	9	10	Worst Possible __________

nyeri

Nyeri adalah keluhan yang paling banyak dijumpai pada pasien kanker stadium lanjut.

Skala Angka (Numeric Rating Scale)

THREE-STEP ANALGESIC LADDER
FREEDOM FROM CANCER PAIN
3
• Opioid for moderate to severe pain
• +/ - Non-opioid
• +/ - Adjuvant
PAIN PERSISTING OR INCREASING
2
• Opioid for mild to moderate pain
• +/ - Non-opioid
• +/ - Adjuvant
PAIN PERSISTING OR INCREASING
1
• Non-opioid
• +/ - Adjuvant
The concept of a ladder explains the need for pain assessment and for appropriate management of pain based on the severity of pain.
https://www.who.int/ncds/management/en/

PENGGUNAAN ANALGESIK UNTUK TATALAKSANA NYERI

		ANALGESIK	OBAT PILIHAN	OBAT LAIN
STEP 1	Nyeri	Non opioid		
Ringan		Adjuvan		
1,2,3				
STEP 2	Nyeri	Opioid lemah	Codein	Tramadol
Sedang	menetap atau	Non opioid		
4,5,6	meningkat	Adjuvan		
STEP 3	Nyeri	Opioid kuat	Morfin	Fentanil
Berat	menetap atau	Non opioid	`	
7,8,9,10	meningkat	Adjuvan		

Pain

Recommended medicines for inclusion:

IBUPROFEN and MORPHINE

Recommended formulations for inclusion:

Ibuprofen:

Oral liquid: 200 mg/5 mL

Tablet: 200 mg; 400 mg; 600 mg.

Morphine:

Granules (modified release) (to mix with water): 20 mg; 30 mg; 60 mg; 100 mg; 200 mg.

Injection: 10 mg/mL

Oral liquid: 10 mg/5 mL

Tablet (controlled release): 10 mg; 30 mg; 60 mg.

Tablet (immediate release): 10 mg.

Tata laksana rehabilitasi medik non medikamentosa pada nyeri kanker paliatif, yakni :

pemberian modalitas TENS/interferensial , superficial heating, massage, relaksasi, breathing exercise, muscle and joint exercise, propper body positioning, dan pada kasus metastase di tulang belakang, diberikan spinal ortose.

anoreksia - kaheksia

Anorexia pada pasien stadium lanjut sering kali bukan menjadi keluhan pasien tetapi keluhan keluarga.

Hilangnya nafsu makan sering dihubungkan dengan rasa penuh dan cepat kenyang. Anorexia biasanya merupakan gejala

Anorexia-Cachexia Sindrom atau kondisi yang lain.

Anorexia (appetite loss)

Recommended medicine for inclusion:

DEXAMETHASONE

Recommended formulations for inclusion:

Injection: 4 mg/mL in 1-mL ampoule (as disodium phosphate salt)

Oral liquid: 2 mg/5 mL

New recommended formulation for addition:

Dexamethasone tablet 4mg

7p

- **Preference** - *establish likes and dislikes*.
- **Palatable** - *food should be what the person. fancies, perhaps with cream/ butter to add calories.*
- **Presentation** - *food should be visually appealing and appetising*.
- **Portions** - *smaller plates for smaller portions.*
- **Position** - *ensure you and the person being assisted are in a comfortable position for eating.*
- **Patience** - *let the person take their own time.*
- **Provide** - *good mouth care regularly, whether eating and drinking or not.*

https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/publications/2015/june/getting-it-right-every-time.pdf?la=en

mual / muntah

Mual dan muntah adalah salah satu keluhan yang sangat mengganggu pasien.

Penyebabnya biasanya lebih dari satu macam.

Mual dapat terjadi terus menerus atau intermiten.

Nausea and Vomiting

Recommended medicine for inclusion:

METOCLOPRAMIDE

Recommended formulations for inclusion:

Injection: 5 mg (hydrochloride)/mL in 2-mL ampoule.

Oral liquid: 5 mg/5 mL

Tablet: 10 mg (hydrochloride)

Tata laksana mual dan muntah harus disesuaikan dengan penyebabnya.

- Hiperasiditas menyebabkan mual, rasa pahit dan nyeri lambung Bila sesudah muntah keluhan masih ada, berikan proton pump inhibitor seperti **omeprazole** 20 mg atau **ranitidine** 300 mg PO.
- Mual akibat iritasi mukosa karena pemberian NSAID: omeprazol 20 mg PO.
- Mual akibat kemoterapi atau radiasi: 5-HT3-reseptor antagonis: **ondansetron 4 mg 1-2x/hari**
- Plus dexamethasone 4 mg pagi hari.

konstipasi

Terdapat berbagai penyebab konstipasi pada pasien dengan penyakit stadium lanjut sbb:

1) Diet rendah serat, kekurangan cairan
2) Imobilitas
3) Tidak segera ke toilet pada saat rasa bab muncul
4) Obat: opioid. anti-cholinergic, antacid yang mangandung alumunium, zat besi, antispasmodic, antipsikotik/anxiolitik.
5) Obstruksi saluran cerna: faeces, tumor, perlengketan
6) Gangguan metabolism: hiperkalsemia
7) Gangguan saraf gastrointestinal, neuropati sarat otonom

Medikamentosa:

- **Obat untuk mencegah konstipasi harus diberikan pada pasien yang mendapat opioid.** Gunakan laksatit yang mengandung **pelembut faeces dan stimulan peristaltik**.
- Bila konstipasi telah terjadi: bisacodyl 10 mg dan glyserin supositoria. Jangan berikan laxative stimulant pada obstruksi.
- Gunakan laksatif pelembut feses atau osmotik pada obstruksi partial.
- **Jika pemberian laksatif gagal, lakukan *Rectal Touch*.**

1) Jika feses encer, berikan 2 tablet bisacodyl atau microlax
2) Jika feses keras, berikan 2 gliserin supositoria
3) Jika rectum kosong, lakukan foto abdomen

diare

Diare dapat terjadi karena beberapa sebab, di antaranya adalah adanya infeksi, malabsorbsi, obstruksi partial, karsinoma kolorektal, kompresi tulang belakang, penggunaan antibiotik, kemoterapi atau radiasi, dan kecemasan.

Diarrhoea

New recommended medicine for addition: LOPERAMIDE

New recommended formulation for addition:

Loperamide 2mg tablet or capsule

Dyspnoea *(breathlessness)*

Merasa tidak bisa bernafas!

Dyspnoea (breathlessness)

Recommended medicine for inclusion:

MORPHINE

Recommended formulations for inclusion:

Granules (modified release) (to mix with water): 20 mg; 30 mg; 60 mg; 100 mg; 200 mg.

Injection: 10 mg/mL

Oral liquid: 10 mg/5 mL

Tablet (immediate release): 10 mg.

Tablet (controlled release): 10 mg; 30 mg; 60 mg.

fatique / kelemahan

Kelemahan umum dan cepat lelah adalah keluhan yang banyak dijumpai pada pasien paliatif.

Hal ini sangat memengaruhi kualitas hidup pasien.

Bagi keluarga, timbulnya keluhan ini sering diinterpretasikan bahwa pasien menyerah.

Fatigue

Recommended medicine for inclusion:

DEXAMETHASONE

Recommended formulations for inclusion:

Injection: 4 mg/mL in 1-mL ampoule (as disodium phosphate salt)

Oral liquid: 2 mg/5 mL

New recommended formulations for addition:

Tablet 4mg

delirium

Delirium adalah kondisi bingung yang terjadi secara akut dan perubahan kesadaran yang muncul dengan perilaku yang fluktuatif. Gangguan kemampuan kognitif mungkin merupakan gejala awal dari delirium.

Delirium sangat mengganggu keluarga karena adanya disorientasi, penurunan perhatian dan konsentrasi, tingkah laku dan kemampuan berfikir yang tidak terorganisir, ingatan yang terganggu dan kadang muncul halusinasi.

Delirium (Confusion)

Recommended medicine for inclusion:

HALOPERIDOL

Recommended formulations for inclusion:

Injection: 5 mg in 1-mL ampoule.

Oral liquid: 2 mg/mL

Solid oral dosage form: 0.5 mg; 2mg; 5 mg

depresi

Harus dibedakan antara depresi dan sedih. Sedih adalah reaksi normal pada saat seseorang kehilangan sesuatu. Lebih sulit mendiagnosa depresi.

Kadang diekspresikan sebagai gangguan somatik. Kadang bercampur dengan kecemasan.

Kemampuan bersosialisasi sering menutupi adanya depresi.

Depresi adalah penyebab penderitaan yang reversible.

Depression

Recommended medicines for inclusion:

AMITRIPTYLINE and FLUOXETINE

Recommended formulations for inclusion:

Amitriptyline: Tablet: 10 mg; 25 mg

Fluoxetine: solid oral dosage form 20 mg (as hydrochloride)

New recommended dosage forms for addition:

Amitriptyline: tablet 75mg

kecemasan

Cemas dan takut banyak dijumpai pada pasien stadium lanjut. Cemas dapat muncul sebagai respon normal terhadap keadaan yang dialami.

Mungkin gejala dari kondisi medis, efek samping obat seperti bronkodilator, steroid atau metilfenidat atau reaksi fobia dari kejadian yang tidak menyenangkan seperti kemoterapi.

Anxiety

Recommended medicines for inclusion:

DIAZEPAM **and** LORAZEPAM

Recommended formulations for inclusion:

Diazepam:

Injection: 5 mg/mL

Oral liquid: 2 mg/5 mL

Rectal solution: 2.5 mg; 5 mg; 10 mg.

Tablet: 5 mg; 10 mg.

Lorazepam:

New recommended formulation for addition:

Lorazepam: tablets 1mg and 2.5mg

Respiratory Tract Secretions

Death rattle

= a gurgling sound heard in a dying person's throat.

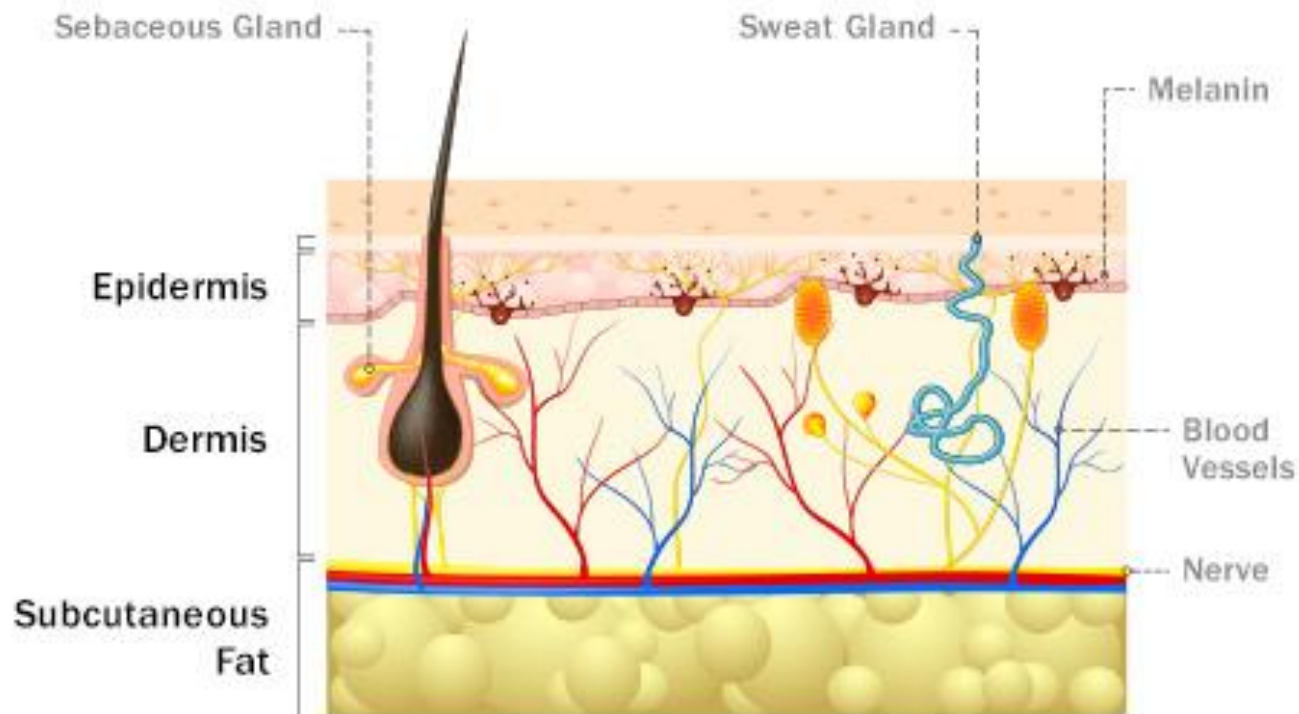
Respiratory Tract Secretions

New recommended medicine for addition:

HYOSCINE BUTYLBROMIDE

New recommended formulation for addition:

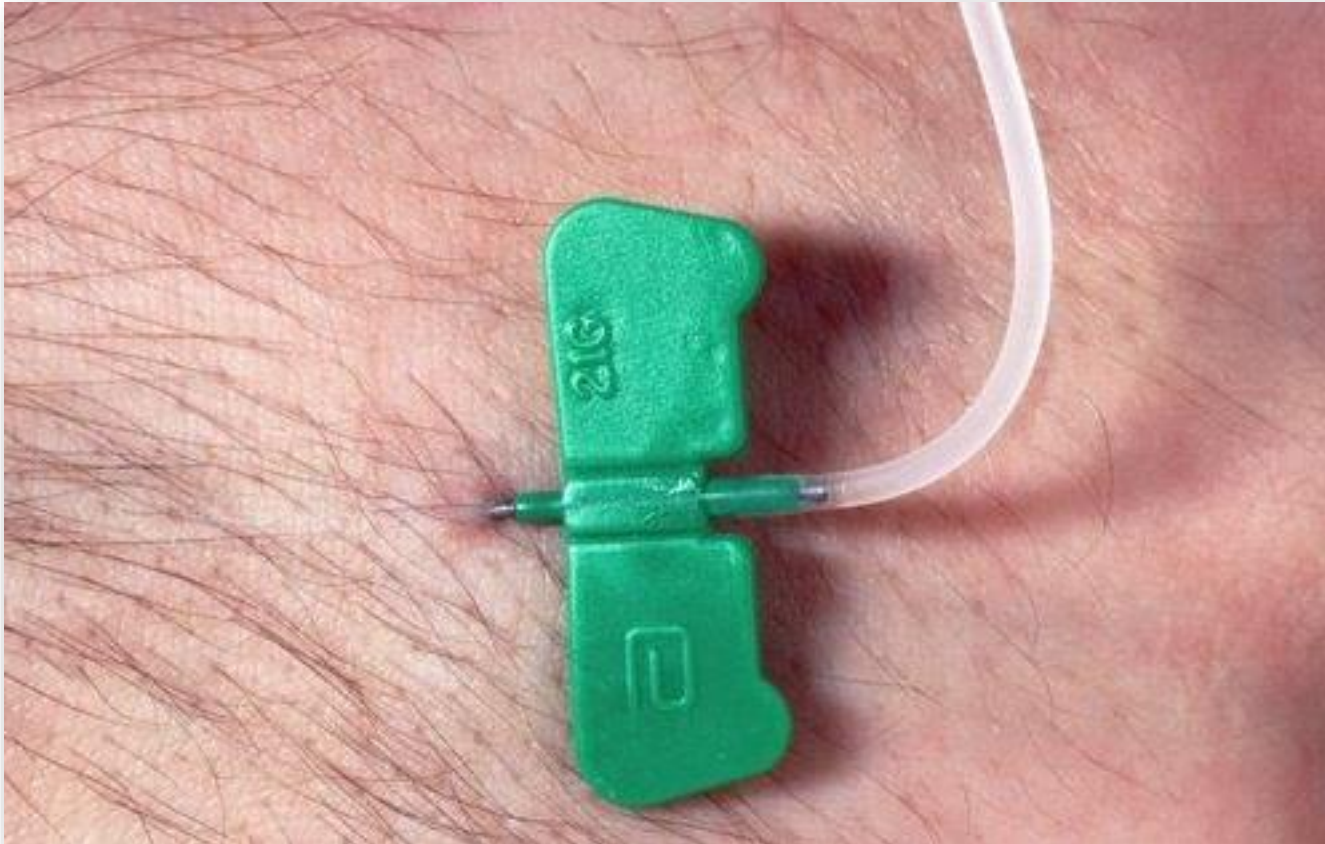
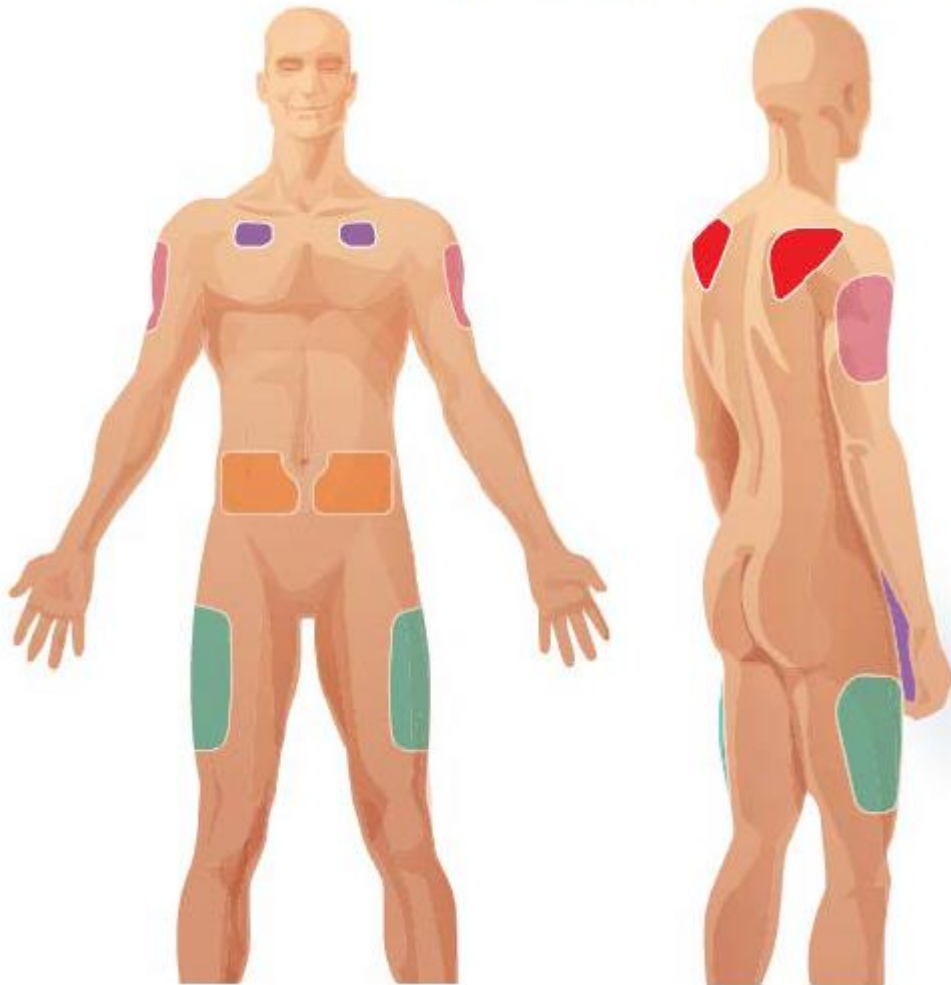
10 mg/mL injectable

masalah kulit

ULKUS DEKUBITUS

Anticipatory Medicines

‘Just in Case’ medicines

- Pain
- Shortness of breath
- Sickness/Nausea
- Secretions in the throat
- Restlessness/agitation

Infus dan Injeksi Subkutan

SUBCUTANEOUS INSERTION SITES

Upper Back (Scapula)
Use when other sites unsuitable or client confused/restless

Subclavicular Area
Avoid when client:

- has lung disease
- is active (risk of pneumothorax)

Upper Arms
Avoid if possible for HDC

Abdomen
Avoid in presence of tense abdominal pressure

Thighs
Best location for HDC

When Death Nears:

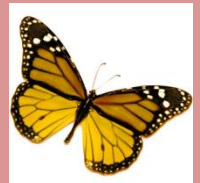
- Sleeping
- Loss of Interest in Food and Fluids
- Coolness
- Changes in Skin Color
- Rattling Sounds in the Lungs and Throat
- Bladder and Bowel Changes
- Disorientation and Restlessness
- Surge of Energy
- Breathing Pattern Changes

MOTTLED SKIN

Mottled skin occurs before death and is a strong indicator that death is imminent.

WITHHOLD & WITHDRAW

Tidak memberikan dan Menghentikan

Obat-obatan, Tindakan dan Pemeriksaan mungkin perlu dipertimbangan untuk tidak diberikan, dan yang sudah diberikan tidak diberikan lagi.

Sesuai prinsip perawatan paliatif, tujuan terapi pada pasien stadium terminal adalah untuk mencapai kondisi nyaman dan meninggal secara bermartabat.

Sehingga terapi yang diberikan bertujuan untuk memperpanjang proses kematian harus dihentikan dan terapi yang tidak sesuai dengan tujuan di atas tidak mungkin diberikan.

2. Reviewing Regular Medication.

The patient may have an altered level of consciousness or significantly reduced oral intake and therefore struggle to swallow medication. Review current medication and discontinue any medication that is no longer of benefit to the patient. For example:

Anti-Hypertensives	Corticosteroids	Hypoglycaemics*
Antibiotics**	Diuretics**	Iron / Vitamin preparations
Anti-arrhythmics	Haematinics	Statins
Anti-coagulants	Hormone therapy	Steroids (long term)***

Palliative sedation

In medicine, specifically in end-of-life care, palliative sedation (also known as terminal sedation, continuous deep sedation, **or sedation for intractable distress in the dying/of a dying patient)** is the palliative practice of relieving distress in a terminally ill person **in the last hours or days of a dying** patient's life,

From Wikipedia

Palliative sedation

usually by means of a continuous intravenous or subcutaneous infusion **of a sedative drug**, or by means of a specialized catheter designed to provide comfortable and discreet administration of ongoing medications via the rectal route.

From Wikipedia

DEATH

Here are indications
that death has occurred:

- **No breathing for a prolonged period of time**
- **No heartbeat**
- **Eyes are fixed and slightly open, with enlarged pupils**
- **Jaw relaxed, with the mouth slightly open**

KHUSNUL KHATIMAH

Principles of a good death

1. · To know when death is coming, and to understand what can be expected
2. · To be able to retain control of what happens
3. · To be afforded dignity and privacy
4. · To have control over pain relief and other symptom control
5. · To have choice and control over where death occurs (at home or elsewhere)
6. · To have access to information and expertise of whatever kind is necessary
7. · To have access to any spiritual or emotional support required
8. · To have access to hospice care in any location, not only in hospital
9. · To have control over who is present and who shares the end
10. · To be able to issue advance directives which ensure wishes are respected
11. · To have time to say goodbye, and control over other aspects of timing
12. · To be able to leave when it is time to go, and not to have life prolonged pointlessly

KHUSNUL KHATIMAH

Principles of a good death

- The ability to anticipate death and manage expectations
- Access to any necessary information resources and support, both spiritual and emotional
- Control over the situation, including pain relief, privacy, location of death and individuals present, combined with confidence that any predetermined instructions will be followed
- Maintenance of a sense of dignity
- Avoidance of needless prolonging of life, balanced with adequate time to say goodbye

https://www1.racgp.org.au/ajgp/2018/november/home-based-palliative-care

London End of Life Care Clinical Network

London
Strategic Clinical Networks

What is a good death?

A good death is the best death that can be achieved in the context of the individual's clinical diagnosis and symptoms, as well as the specific social, cultural and spiritual circumstances, taking into consideration patient and carer wishes and professional expertise.

A supportive culture that fosters excellence, confidence, innovation and education in all staff with the aim of improving outcomes

Timely assessment and provision of bereavement services

Care which is competent, confident, compassionate and personalised, in line with recognised best practice standards

Joined up, co-ordinated services and pathways which are easy to access and navigate

Access to spiritual and psychological support

Tailored pain management

London Strategic Clinical Networks | 105 Victoria Street, London, SW1E 6QT | england.london-scn@nhs.net | londonscn.nhs.uk

http://www.londonscn.nhs.uk/wp-content/uploads/2014/11/eolc-good-death-definition-052015.pdf

An article in the Journal of the American Medical Association found that there is no one definition of a good death; quality end-of-life care is a dynamic process that is negotiated and renegotiated among patients, families, and health care professionals. http://www.bbc.co.uk/ethics/euthanasia/overview/gooddeath.shtml

FUNERAL

Providing good psychosocial care comes down to good communication skills, both verbal and non-verbal.

PALLIATIVE CARE

TAMAN PALIATIF
RSUP DR KARIADI SEMARANG, 2019

BIMTEK PELAYANAN PERAWATAN PALIATIF DAN AKHIR KEHIDUPAN
RSUD TUGUREJO
KAMIS, 13 FEBRUARI 2020

Yayasan Paliatif Surabaya

Prof. Sunaryadi

SEPENGGAL KISAH

BAPAK PALIATIF INDONESIA

Penulis: Leo Larantukan

Nama:

Prof. Raden Sunaryadi Tejawinata, dr. SpTHT(K-Onk), FICS, FAAO, PGD, Pall.Med.(ECU)

Lahir:

Cirebon, 23 Agustus 1934

Prof. Sunaryadi

BAPAK PALIATIF INDONESIA

DEKLARASI PERDOPIN

(Perhimpunan Dokter Paliatif Indonesia)

Surabaya, 22 Februari 2014

APHC 2019 - 13th Asia Pacific Hospice Conference

Aug 01 - 04, 2019, Surabaya

TAKE HOME MASSAGES

Palliative care allows for medical therapies, but focuses on:

- Improving quality of life
- Relieving symptoms (for example pain) and stress
- Reaching the best possible function (for example, daily activities, physical activity, and self-care)
- Helping with decision-making about end-of-life care
- Providing emotional support to patients and their families

https://www.stanfordchildrens.org/en/topic/default?id=palliative-care-90-P03053

TAKE HOME MASSAGES

1. **identify:** earlier identification and recognition of patients in final year/s:
   - to ensure equity of access, leading to better proactive planning of care for all
2. **assess**: use advance care planning discussions:
   - to clarify people's needs, wishes, and expectations
3. **plan:** planning for patients to live well and die well where they choose:
   - through better coordinated care, reducing hospitalisation.

https://www.guidelinesinpractice.co.uk/cancer/going-for-gold-helps-to-improve-access-to-better-end-of-life-care/352561.article

TAKE HOME MASSAGES

1. Each person is seen as an individual
2. Each person gets fair access to care
3. Maximising comfort and wellbeing
4. Care is coordinated
5. All staff are prepared to care
6. Each community is prepared to help.

https://www.england.nhs.uk/wp-content/uploads/2016/01/transforming-end-of-life-care-acute-hospitals.pdf

TAKE HOME MASSAGES

7c

The seven Cs of primary palliative care

- Communication
- Coordination
- Control of symptoms
- Continuity of care
- Continued learning
- Carer support
- Care of the dying pathway

https://www.mja.com.au/journal/2010/193/2/palliative-care-beyond-cancer-australia

SUGGESTED READING

RESOURCES TO SUPPORT YOUR CONTINUED LEARNING ABOUT PALLIATIVE CARE AND END OF LIFE CARE

- https://acclaimhealth.ca/programs/palliative-care-consultation/palliative-care-resources
- https://www.palliativecareguidelines.scot.nhs.uk/guidelines.aspx
- https://www.ontariopalliativecarenetwork.ca/en/node/31896
- http://www.mhpcn.net/palliative-care-toolbox
- https://library.nshealth.ca/PalliativeCare
- https://palliativecareindonesia.blogspot.com

STANDAR NASIONAL AKREDITASI RUMAH SAKIT
(Edisi 1)

Rumah sakit menetapkan proses untuk mengelola **ASUHAN PASIEN DALAM TAHAP TERMINAL.**

Proses ini meliputi

a) intervensi pelayanan pasien untuk mengatasi nyeri;
b) memberikan pengobatan sesuai dengan gejala dan mempertimbangkan keinginan pasien dan keluarga;
c) menyampaikan secara hati-hati soal sensitif seperti autopsi atau donasi organ;
d) menghormati nilai, agama, serta budaya pasien dan keluarga;
e) mengajak pasien dan keluarga dalam semua aspek asuhan;
f) memperhatikan keprihatinan psikologis, emosional, spiritual, serta budaya pasien dan keluarga.

http://www.pdpersi.co.id/kanalpersi/manajemen_mutu/data/snars_edisi1.pdf

BIMTEK PELAYANAN PERAWATAN PALIATIF DAN AKHIR KEHIDUPAN
RSUD TUGUREJO, SEMARANG. (13 FEBRUARI 2020)

BIMTEK PELAYANAN PERAWATAN PALIATIF DAN AKHIR KEHIDUPAN
RSUD TUGUREJO
KAMIS, 13 FEBRUARI 2020

THANK YOU

https://palliativecareindonesia.blogspot.com/2019/12/dari-sebuah-rintisan-menuju-paripurna.html